

**SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
CHILD PROTECTION SERVICES
PLACEMENT RESOURCE MONTHLY REPORTING FORM**

This tool is to be used by all placement providers to convey to the assigned family services specialist the current status of each child in placement. This process is to be completed each month. The completed report is to be sent to the child's assigned family services specialist along with the monthly billing form. The information you share is critical in assessing the child's safety, permanence, and well being.

****NOTE**** All information pertaining to the child must be completed on the child's first/initial monthly reporting form.

CHILD: _____ **BIRTHDATE:** _____ **AGE:** _____

REPORTING MONTH _____ **YEAR** _____

FAMILY SERVICES SPECIALIST: _____

PLACEMENT RESOURCE NAME: _____

BIRTH TO THREE YEARS INFORMATION

First tooth:	<input type="checkbox"/>
Crawled for the first time:	<input type="checkbox"/>
Stood for the first time:	<input type="checkbox"/>
Walked for the first time:	<input type="checkbox"/>
First Word:	<input type="checkbox"/>
First Sentence:	<input type="checkbox"/>
Succeeded in toilet training:	<input type="checkbox"/>
Stopped drinking from a bottle:	<input type="checkbox"/>
Started drinking out of a cup:	<input type="checkbox"/>

Developmental milestones achieved this month: _____

Comments (List favorite foods, likes/dislikes, sleeping schedule, etc.): _____

Family Services Specialist Comments: _____

PHYSICAL HEALTH-MEDICAL/DENTAL/VISION

Child's general health this month: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Dr. Name: _____ **Phone** _____

Address: _____

Medical appointment dates: _____ **None** ☐
(*Follow EPSDT/Healthy Kids Club Schedule)

Reason for appointment: _____

Approximate date of next medical/physical exam: _____ None ☐

Dentist Name: _____ **Phone** _____

Address: _____

Dental appointment dates: _____ None ☐
 (*DENTAL NEEDS TO BE COMPLETED YEARLY or as needed)

Reason for appointment: _____

Approximate date of next semi annual cleaning/exam: _____ None ☐

Optometrist Name: _____ **Phone** _____

Address: _____

Vision appointment dates: _____ None ☐
 (*VISION NEEDS TO BE COMPLETED YEARLY-school exams can be used)

Reason for appointment: _____

Comments: _____

Family Services Specialist Comments: _____

EMOTIONAL HEALTH

Self Esteem: Excellent ☐ Good ☐ Poor ☐

Attitude/behavior: Excellent ☐ Good ☐ Poor ☐

Mood swings: Yes ☐ No ☐

Withdraws-keeps to self: Yes ☐ No ☐

Birth family issues: Yes ☐ No ☐

Child attends counseling: Yes ☐ No ☐ NA ☐ Number of sessions attended this month: _____

☐ I/we attended _____ number of counseling sessions with the child this month.

☐ Is the counseling meeting the needs of the child? Yes ☐ No ☐

Comments: _____

Family Services Specialist Comments: _____

MEDICATIONS:

N/A: ☐

List on-going medication (s) prescribed: _____

List dosage change(s): _____

List new medication (s) prescribed: _____

Comments: _____

Family Services Specialist Comments: _____

SELF SUFFICIENCY

Completes chores without reminders or coaxing: Yes ☐ No ☐ Sometimes ☐ NA ☐

Does a chore only with reminders and/or directions: Yes ☐ No ☐ Sometimes ☐ NA ☐

Starts homework without being told: Yes ☐ No ☐ Sometimes ☐ NA ☐

Continues homework until all lessons are done: Yes ☐ No ☐ Sometimes ☐ NA ☐

Wakes self up and gets ready on time: Yes ☐ No ☐ Sometimes ☐ NA ☐

Goes to bed on time: Yes ☐ No ☐ Sometimes ☐ NA ☐

Sleeps through the night: Yes ☐ No ☐ Sometimes ☐ NA ☐

Does own laundry: Yes ☐ No ☐ Sometimes ☐ NA ☐

Offers to help others around the house: Yes ☐ No ☐ Sometimes ☐ NA ☐

Practices daily hygiene: Yes ☐ No ☐ Sometimes ☐ NA ☐

Money Management: Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Job skills/responsible to job duty: Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Comments: _____

Family Services Specialist Comments: _____

**FAMILY CONNECTIONS, RELATIONSHIPS,
AND CULTURAL/TRADITIONAL CONNECTIONS**

This section focuses on the preservation of the child's primary connections, including their relationship with birth family, previous foster families, schools, friends, communities, tribes/tribal customs, religion/religious, and traditional observances.

BIRTH FAMILY CONNECTIONS:

With mother: Yes ☐ No ☐ NA ☐ Visits: Yes ☐ No ☐ NA ☐

With father: Yes ☐ No ☐ NA ☐ Visits: Yes ☐ No ☐ NA ☐

With sibling (s): Yes ☐ No ☐ NA ☐ Visits: Yes ☐ No ☐ NA ☐

With extended family/kin: Yes ☐ No ☐ NA ☐ Visits: Yes ☐ No ☐ NA ☐

Comments: _____

Family Services Specialist Comments: _____

RELATIONSHIPS:

Relationship with your family/staff: Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Relationship with birth family: Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Relationship with peers: Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Relationship with family services specialist:
Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Relationship with authority figures: Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Able to express feelings and thoughts: Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Comments: _____

Family Services Specialist Comments: _____

CHILD CONNECTIONS:

Awareness of their culture/ethnic background:

Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Relates well to resource family's culture/ethnic background:

Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Acceptance/awareness of other's culture/ethnic background:

Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Family Tradition activities: _____

Cultural Tradition activities: _____

Comments: _____

Family Services Specialist Comments: _____

RELIGION/SPIRITUAL DEVELOPMENT:

Does the child have the opportunity to practice a faith of their choice? Yes ☐ No ☐

Conflicts or issues about religion: Yes ☐ No ☐

Comments: _____

Family Services Specialist Comments: _____

LIFE BOOK

This should begin shortly after placement; family services specialists need to bring the materials needed for the foster parent to add items as events happen in the child's life.

Have you received a life book binder and the packet of life book information? Yes: ☐ No: ☐

Has the book been started: Yes: ☐ No: ☐ N/A: ☐

If no or N/A, why: _____

Has been started but DID NOT WORK ON THIS MONTH: ☐

Progress on life book this month: _____

Worked on by:

foster parent: Yes ☐ No ☐ NA ☐

Child involved: Yes ☐ No ☐ NA ☐

group/residential staff: Yes ☐ No ☐ NA ☐

Child involved: Yes ☐ No ☐ NA ☐

family services specialist: Yes ☐ No ☐ NA ☐ Child involved: Yes ☐ No ☐ NA ☐

Supplies needed for life book: _____

Comments: _____

Family Services Specialist Comments: _____

EDUCATIONAL DEVELOPMENT

Child in school: Yes ☐ No ☐

Early intervention program: Yes ☐ No ☐

Attitude/behavior with teachers and staff:

Excellent ☐ Good ☐ Fair ☐ Needs work ☐ No effort given ☐

Attitude/behavior with peers: Excellent ☐ Good ☐ Fair ☐ Needs work ☐ No effort given ☐

Attitude/behavior toward homework:

Excellent ☐ Good ☐ Fair ☐ Needs work ☐ No effort given ☐

Overall effort toward schoolwork: Minimum effort ☐ Average effort ☐ Maximum effort ☐

Grade Point Average: _____

Your relationship with the school: Excellent ☐ Good ☐ Fair ☐ Poor ☐

School conference: Yes ☐ No ☐ Did you attend: Yes ☐ No ☐

Do you have a copy of the school records: Yes ☐ No ☐ NA ☐

Copy of report card to family services specialist: Yes ☐ No ☐ NA ☐

School pictures copy for file: Yes ☐ No ☐ NA ☐

Graduation pictures/announcements: Talked to worker ☐ NA ☐

Child on Individual Educational Plan (IEP): Yes ☐ No ☐ Date of last IEP: _____
Did you attend: Yes ☐ No ☐

Child on Individual Family (IFSP): Yes ☐ No ☐ Date of last IFSP: _____
Did you attend: Yes ☐ No ☐

Days absent: _____ Days Tardy: _____

Conflicts at school: Teacher: _____ Subject: _____ NA ☐

Comments: _____

Family Services Specialist Comments: _____

COMPETENCE AND ACHIEVEMENTS

Participation in extra curricular activities: Yes ☐ No ☐ Sometimes ☐ NA ☐

Maintains hobbies: Yes ☐ No ☐ Sometimes ☐ NA ☐

Develops/works on talents or achievements: Yes ☐ No ☐ Sometimes ☐ NA ☐

Started new sport, hobby, or talent: Yes ☐ No ☐ Sometimes ☐ NA ☐

Stopped participating in sport, hobby, and talent: Yes ☐ No ☐ Sometimes ☐ NA ☐

If yes, why: _____

Comments: _____

Family Services Specialist Comments: _____

DISCIPLINE

Behavior concerns?: _____

What type of discipline have you used this month?: _____

How did the child respond?: _____

Frequency of discipline?: _____

Is there training or educational material that would help you increase your effectiveness in parenting this child? _____

Comments: _____

Family Services Specialist Comments: _____

RESPIRE

Have you used respite this month: Yes ☐ No ☐ If yes, who provided respite?: _____

Was respite pre-arranged?: Yes ☐ No ☐ Do you have a need for respite?: Yes ☐ No ☐

(If you need respite, you must specifically talk with the child's family services specialist or the office licensing worker to make arrangements.)

Comments: _____

Family Services Specialist Comments: _____

INDEPENDENT LIVING SKILL (ILS) TRAINING FOR ADOLESCENTS

(Complete this section only if you have a child 16 years old or older in your home/facility)

Did your foster youth attend any ILS training this month: Yes ☐ No ☐ NA ☐

Topics: _____

Workshop: ☐ Teen Conference: ☐ Community Resource Person: ☐ Other: ☐ _____

Date: _____ Has the Ansel Casey Assessment been completed: Yes ☐ No ☐

Have you received a copy?: Yes ☐ No ☐

List any training areas that you would like to discuss: _____

Youth 16 and above had contact with Community Resource Person: Yes ☐ No ☐ NA ☐

I/we worked on the following ILS activities with the youth (i.e. budgeting, meal preparation, daily living tasks, career planning, etc.) _____

Comments: _____

Family Services Specialist Comments: _____

LEGAL INVOLVEMENT

Attended court hearing: Yes ☐ No ☐ N/A ☐ Date: _____ Hearing type: _____

Were you given written notification of court hearing: Yes ☐ No ☐ NA ☐

Were you given the opportunity to be heard orally or in writing: Yes ☐ No ☐ NA ☐

If no, reason?: _____

This question only needs to be answered at the time of the Permanency Planning Review Team (PPRT) (which is every 6 months) Were you given notice of the PPRT: Yes ☐ No ☐ NA ☐
Date: _____ Attendance: Yes ☐ No ☐

PERMANENCY PLAN

Reunification ☐
Adoption ☐

Kinship ☐
Other Alternative long term plan ☐

Guardianship ☐
Emancipation ☐

Do you see movement toward achieving the permanent plan: Yes ☐ No ☐

Comments: _____

Did you actively contribute and participate in development of the case plan: Yes ☐ No ☐

Did the child actively contribute and participate in development of the case plan: Yes ☐ No ☐

Is the case plan current: Yes ☐ No ☐ Did you receive a copy?: Yes ☐ No ☐

Was there a visit from the CASA worker or Guardian ad Litem this month: Yes ☐ No ☐ NA ☐

Type of Contact: _____

Did the child's attorney have contact with the child this month: Yes ☐ No ☐ NA ☐

Type of Contact: _____

Comments: _____

Family Services Specialist Comments: _____

PURCHASES

(Clothing and major expenses)

Item: _____ Cost: _____

Item: _____ Cost: _____

Item: _____ Cost: _____

Item: _____ Cost: _____

Item: _____ Cost: _____

Item: _____ Cost: _____

Comments: _____

Family Services Specialist Comments: _____

MONTHLY ASSESSMENT OF DSS/CPS STAFF

Quality of home visit: Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Communication with family services specialist:

Excellent ☐ Good ☐ Fair ☐ Needs work ☐ NA ☐

Number of home visits: _____

Number of family services specialist/child face to face contacts: _____

(*Visits are defined as face-to-face contacts between the family services specialist and the child. Please indicate in comments if you have had additional contact with your child's family services specialist via e-mail or telephone.)

Comments: _____

Family Services Specialist Comments: _____

SIGNATURE DATE

FAMILY SERVICES SPECIALIST SIGNATURE DATE

SUPERVISOR INITIAL

NOTES AND TOPICS DISCUSSED AT MONTHLY HOME VISIT ON THIS DATE _____

ASSESSMENT OF CHILD SAFETY AND PLACEMENT STABILITY _____

SIGNATURE DATE

FAMILY SERVICES SPECIALIST SIGNATURE DATE

SUPERVISOR INITIAL